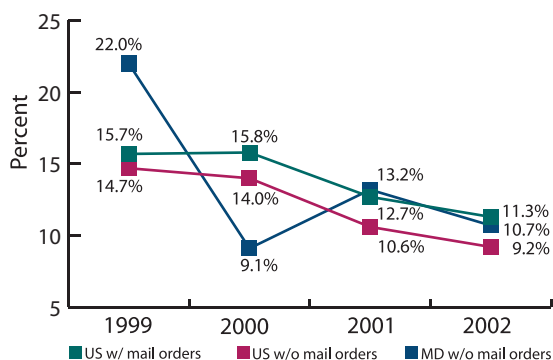




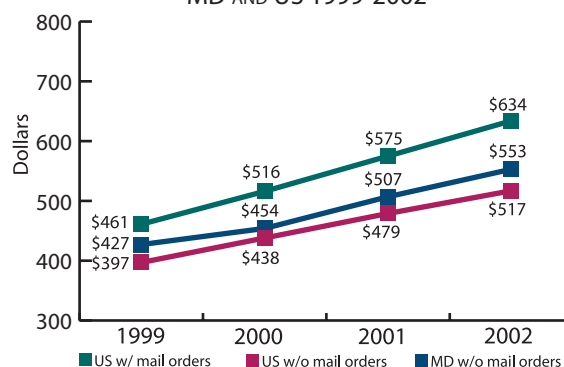
Rise in Prescription Drug Spending Continues But Growth Rate is Lower

In 2002, consumer spending on retail store prescription drugs reached an estimated \$3.0 billion in Maryland and over \$149 billion nationwide.¹ Prescription drugs have been one of the fastest growing segments of health care spending both nationally and in Maryland, but the growth rate, as measured by retail sales, has been slowing for 2-3 years. Between 2001 and 2002, estimated retail store sales (which excludes prescriptions purchased through mail order channels) of prescription drugs grew by 11 percent in Maryland, compared to 9 percent nationwide. Maryland's rate of growth in prescription drug sales has tended to be above the national average in recent years, but when sales trends are adjusted for population increases, the gap between the growth rates narrows. Per capita retail store sales for Maryland in 2002 averaged \$553 per resident, up 9 percent over 2001, compared to national estimates of \$517 and 8 percent growth. Compared to nearby states, Maryland's per capita figure is above Virginia's (\$439) but below those of Delaware (\$589), Pennsylvania (\$611), and New Jersey (\$672).

GROWTH IN RETAIL PRESCRIPTION DRUG SALES,
MD AND US 1999-2002¹



PER CAPITA RETAIL SALES OF PRESCRIPTION DRUGS,
MD AND US 1999-2002¹



Changing Marketplace for Prescription Drugs

Over the past decade, the retail marketplace for prescription drugs has changed in several ways. Key among them is a dramatic increase in the use of prescription drug insurance, especially coverage obtained through employers. According to David Knapp, Dean of the University of Maryland School of Pharmacy, 85 to 90 percent of working adults today have a prescription drug benefit, compared to 35 percent of workers ten years ago.² The increased availability of drug coverage occurred with the shift from conventional health insurance to managed care plans, which historically focused on providing comprehensive care, including prescriptions and ambulatory coverage, as well as preventive care. Nationwide the share of privately-funded³, retail store prescription drug payments and pharmaceuticals purchased using insurance (as opposed to cash only) has been steadily increasing, rising from 72 percent of retail store payments and 67 percent of retail store prescriptions in 1997 to 86 percent of payments and 83 percent of prescriptions in 2002.

But in Maryland, employment-based insurance is more prevalent than the national average.⁴ Consequently, the reliance on private insurance in retail store prescription sales is even greater: in 2002, 89 percent of the payments and 87 percent of the prescriptions were for drugs covered all or in part by insurance (known as third-party prescriptions), up from 80 percent of payments and 76 percent of prescriptions in 1997. The higher prevalence of prescription drug insurance in the state⁵, along with above-average household incomes⁶, helps to explain why both the per capita expenditure and the

annual growth rate for retail store prescription drug sales are above the national averages.

Mail order sales of prescription drugs, which include sales over the Internet, is the fastest growing retail outlet for prescription drugs. Since 1992, the nationwide mail order share of retail prescription drug sales has more than doubled, from 8.9 to 18.4 percent; during 1999-2002, sales grew annually by an average of 24 percent.⁷ Much of this growth is due to an increased emphasis by employers, health plans, and pharmacy benefit managers on the out-of-pocket savings to workers and enrollees by purchasing drugs through mail order channels compared to purchases made at retail stores. Market shares among the different retail store types in Maryland have also changed. From 1999 to 2002, chain drug stores – which accounted for slightly more than half of the state's retail store prescription drug sales in 2002 – lost some of their market share to supermarkets and, to a lesser extent, mass merchants like Target and Wal-Mart.⁸ The independent drug store share, however, was stable over this period.

Prescription Drug Costs and Volume

Based on retail store sales with a known source of payment, Maryland has a higher average prescription price but a lower per capita number of prescriptions compared to national averages. In 2002, Maryland's average price per prescription was 16 percent above the national average: \$62.71 versus \$53.91, while the average number of prescriptions per capita for Maryland (7.3) was nearly 23 percent below the national average (9.4). Maryland's pattern is consistent with

a system in which residents obtain two or three months of medication in a single retail prescription, resulting in a higher average price per prescription but fewer prescriptions per person. Maryland law requires insurers and HMOs selling prescription drug coverage in the state to permit 90-day supplies of maintenance drugs in a single prescription and to have the same benefit rules for prescriptions purchased through retail stores and mail order outlets.⁹ Neighboring states that do not have these rules average lower prices per retail prescription but have more retail prescriptions per resident.

Factors Driving Pharmacy Benefit Costs for Employers

In general, the growth in employer/insurer pharmaceutical spending is fueled by three main factors: increased use of prescription drugs, with more people using their prescription drug benefit and users filling more prescriptions; increased cost of the average prescription, as the prices of existing drugs continue to rise and patients use more of the higher priced alternatives within a therapeutic category; and expensive new drugs entering the market, which often replace older, less expensive drugs. According to Express Scripts, Inc., a leading pharmacy benefit manager (PBM), employers saw an increase of 18.5 percent in per member per year (PMPY) pharmacy costs from 2001 to 2002.¹⁰ The components of this increase were: 6.3 percent from higher utilization; 11.2 percent from higher prices to employers for common prescriptions, across old users (10.5%) and new users (0.7%); and 1 percent from new drugs. The higher prescription price was driven mainly by inflation in unit prices paid by employers and shifts in employees' therapeutic drug mix to favor higher priced alternatives and higher dosage forms, with greater use of generics exerting a downward influence.

Historically, drug benefits were modeled on the cost-sharing formula used by health maintenance organizations, with all prescriptions, regardless of cost, having the same low co-payment. But in the mid-1990's many new, expensive drugs designed for chronic illnesses came on the market. These high-priced drugs combined with physicians' willingness to prescribe and strong consumer demand (fueled by very low co-payments and direct-to-consumer advertising) to create dramatic increases in drug expenditures. Due to the low co-pays, insurers and employers picked up most of the increase in spending and, in response, they have been redesigning their drug benefits in ways that will make workers (and physicians) pay more attention to drug prices when they make treatment choices.

Benefit Changes to Constrain Costs

Changes in prescription drug benefits were a key factor in the slowed growth rate for retail store prescription drug spending in 2002. The most prevalent of the "cost-conscious" design changes is the three-tier cost-sharing arrangement in which a worker has one co-pay for generic drugs, a higher co-pay for "preferred" brand-name drugs, and an even higher co-pay (or sometimes coinsurance) for non-preferred drugs. The majority (55%) of covered workers, nationwide, had this cost-sharing formula in 2002, up from 27 percent in 2000;

in 2003 even more covered workers (63%) faced this benefit structure.¹¹ A small but growing number of employers are using coinsurance, where the employee pays a percentage of the total payment for the prescription instead of a flat co-pay, to make their employees conscious of the actual prices of the drugs they use. These changes have shifted some of the prescription drug costs from employers to employees.

Other benefit design changes are focused on establishing rules for which drug is provided and where medications are obtained. Step therapy can be used in situations where less expensive but equally effective alternative medications are available within a therapeutic class. Its goal is to have the employee try the less expensive alternative first, with the expensive version being provided only in cases where the lower cost alternative fails. Generally, unless the patient's physician obtains a prior authorization, the pharmacy is instructed to replace initial prescriptions for the expensive versions with a lower cost, generic alternative. It is being employed to curtail excessive use of expensive gastrointestinal, allergy, and pain medications. Prescriptions filled through a pharmacy benefit managers' mail order outlet cost an employer less than if the same prescriptions are filled at retail stores. So, increasing numbers of employers are requiring that employees use the PBM mail order outlets to obtain "maintenance" medications (those that are taken on a daily basis and are purchased in high volumes). Mandatory mail order will have less impact in Maryland: only the state's self-insured employers can make mail orders mandatory.⁹ Among large Maryland-District of Columbia employers serviced by Hewitt Associates, mandatory mail order use was reported by one-third and step therapy was reported by eleven percent.¹²

¹National Association of Chain Drug Stores (NACDS). *The Chain Pharmacy Industry Profile* (2001, 2002, 2003). MHCC analysis of estimated retail sales of prescription drugs provided by NACDS. Maryland (MD) pharmaceutical sales are derived from total store sales in MD; mail order retail sales are reported only at the national level. Unless otherwise noted, this report is the source for figures cited in this expenditure profile.

²Zaneski, Cyril T. Baltimore Sun. *People are swallowing more of the cost of pills*. February 24, 2004.

³Privately-funded includes purchases made using insurance or cash; prescriptions covered by Medicaid are excluded.

⁴During 2001-2002, 73% of the nonelderly in Maryland had employer-based health insurance coverage, compared to 64% nationwide. See *Health Insurance Coverage in Maryland Through 2002*, Maryland Health Care Commission. Available on the Internet at http://mhcc.state.md.us/health_care_expenditures/insurance_coverage.

⁵It is estimated that 99% of workers with employment-based health insurance have prescription drug coverage. See Kaiser/HRET *Survey of Employer-Sponsored Health Benefits: 2003*, Exhibit 8.2. Available on the Internet at <http://kff.org/insurance/ehbs2003>.

⁶Between 2001-2002, the median money income of households in Maryland was \$55,394 compared to \$42,654 in the United States. Citation: U.S. Census Bureau, Current Population Reports, P60-221, *Income in the United States: 2002*, U.S. Government Printing Office, Washington, DC, September 2003.

⁷There is no state-level data on mail order sales.

⁸51.5% of Maryland's 2002 retail store sales (in dollars) were made at chain drug stores. Sales through supermarkets accounted for 24.9% of sales, followed by independent drug stores (14.6%) and mass merchants (9.0%). This differs from the pattern nationwide, where chain pharmacies accounted for 49.2% of the non-mail order sales, independent drug stores (24.6%), supermarkets (14.6%), and mass merchants (11.7%).

⁹Insurance Articles §15-824 and §15-805(d)(2), Annotated Code of Maryland. The latter states that fully insured products may not impose co-payments, deductibles, or other conditions on services obtained through retail pharmacies that are not imposed when the insured uses mail order.

¹⁰Express Scripts, Inc., 2002 Drug trend Report. Increased cost = $f(\text{higher unit prices} \times \text{fewer units per prescription} \times \text{lower priced generics} \times \text{increase due to therapeutic mix})$.

¹¹Kaiser/HRET, 109.

¹²Hewitt Associates, LLC. *Emerging Pharmacy Benefit Management Strategies*, October 2003. Data for Maryland-District of Columbia employers obtained from Hewitt by MHCC.